program. They act as consultants on issues presented by the drug program administrator which may affect future priorities in the program. They also review candidates for the medical management program, based on the recipients drug use history.

C. MEDICAL MANAGEMENT PROGRAM

1. Objectives

The Medical Management program is designed to monitor recipients with a history of over-utilization of services provided by the Medicaid program. Objectives of the Medical Management program are:

a. To identify over-utilization of services by recipients of medical benefits.

b. To assure quality and appropriate care for recipients of medical benefits.

c. To assist in identifying provider problems related to recipient over-utilization.

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2. Organization and Procedures for Medical Management

The Surveillance and Utilization Review (SUR) Unit of the Medical Assistance Division has primary responsibility for placing recipients on the medical management program. Prospective candidates for medical management are identified through several sources:

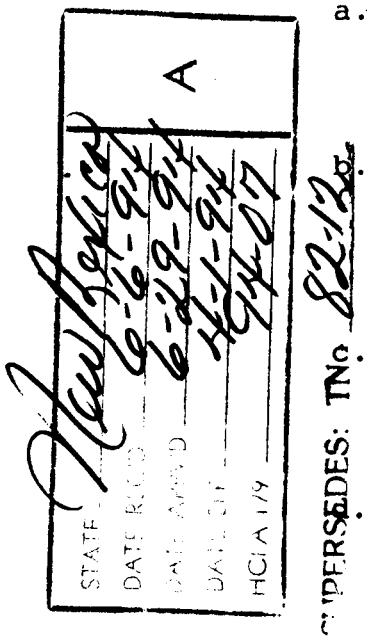
a. Recipients identified by the claims processing agent through appropriate audits and edits in their claims processing system.

b. Recipients identified through sources outside the Medical Assistance Division, i.e., Income Support Division Specialists, private citizen, providers, etc.

c. Recipients identified in the SUR reports, particularly those who have received numerous services, those who have been to several different providers and those for whom Medicaid has paid a large dollar amount.

3. Selection for Medical Management

The SUR staff analyze statistical reports and the claim histories of each candidate for Medical Management. If additional information is needed, other sources, including medical records or information maintained by the claims processing contractor, are analyzed.



a. If the analysis indicates that the individual's aggregate use of service was not medically necessary, the SUR staff develop a recommendation that the individual be assigned to Medical Management.

b. The recommendation includes a description of the utilization problem, information analyzed in making the recommendation, type of restriction(s), designed provider(s), utilization objectives, effective date of the assignment, and date for reevaluation.

c. After reviewing the SUR staff recommendation and supporting documentation, the Medical Director of the Medical Assistance Division determines whether the individual should be assigned to Medical Management.

d. If the individual is to be assigned to Medical Management, the SUR staff notifies the recipient and the claims processing contractor of the assignment. The individual placed on Medical Management receives an identification card which indicates "Medical Management" and the name of the designated provider(s).

Part III - State Agency Monitoring of NMPSRO

It is the responsibility of Professional Standards Review Organizations to determine that services rendered are medically necessary and that the quality of the services meets acceptable professional standards of care. It is desirable, therefore, for states to be able to monitor the performance of PSROs so that they can determine that PSRO review is effective in utilization of services and that State dollars are being appropriately spent for necessary and quality care.

In response to the above the Medical Assistance Bureau has established a plan to monitor the performance of NMPSRO. The monitoring plan focuses on results of the NMPSRO review and avoids overseeing procedures used by the NMPSRO to do its review. In this way the monitoring process is entirely objective.

A. Objectives

1. To determine that the NMPSRO review is being carried out in a timely and accurate manner.

2. To determine that the NMPSRO review follows program policies and guidelines established by the Medical Assistance Bureau.

3. To determine the impact of the NMPSRO review on utilization of services and expenditures.

4. To identify areas of concern which should be addressed by the NMPSRO, the State Agency and the DHHS.

5. To ensure that State and Federal funds for institutional health care and ambulatory health care are being spent appropriately for medically necessary services and quality care.

These objectives are accomplished through several approaches which are discussed below.

B. AMBULATORY CARE MONITORING PLAN

I. Introduction

The Human Services Department contracts with the New Mexico Professional Standards Review Organization for specified services. The Ambulatory Care Monitoring Plan defines the monitoring procedures for the responsibilities identified in the scope of work contained in the contract. The Medical Assistance Bureau of the Human Services Department is responsible for monitoring:

1. Prior Approval Review - the performing of prior approval review for the medical necessity of ambulatory services as specified in the contract.

2. Pre-payment Claims Review - the review of claims of providers on review, emergency room claims and universal claims review for selected procedures.

II. Objectives of PSRO Monitoring

The objectives of the PSRO Ambulatory Monitoring Plan are to insure that the performance standards as specified in the contract are met. Specifically, the objective are as follows:

1. Monitor the timeliness of pre-payment claims review.

2. Monitor the timeliness and accuracy of quarterly statistical reports.

3. Monitor the timeliness of processing prior approval requests.

4. Monitor the review process for adherence to Medical Assistance Bureau program policies, guidelines, and criteria and the PSRO Ambulatory Care Review Manual, for the appropriate level of review, consistency of review and for appropriateness of review determination.

III. Monitoring Methodology

The methodology to be employed in this plan consists of both on-site observation and the review of documents related to the monitoring objectives. In order to accomplish the monitoring, NMPSRO will provide the Medical Assistance Bureau with the following:

1. Advance notice of all scheduled review sessions with notice of all changes in such a schedule.

2. Advance notice of all meetings scheduled for provider groups, peer reviewers, ad hoc committee meetings and Ambulatory Review Committee meetings.

3. Access to files on Medicaid recipients, provider correspondence, professional peer review sessions, claims and prior approval requests scheduled for review, and claims and prior approval requests as handled by the review coordinator or review assistants.

4. Access to internal activity reports.

5. Access to the review sessions.

The following is the specific methodology to be used for each defined monitoring objective:

Objective 1 - Monitor the timeliness of prepayment claims review.

The timeliness of prepayment claims review will be monitored using the weekly aged claim lists produced by the fiscal agent, the process date of claims and worksheets being reviewed at review sessions, the process date of claims and worksheets being returned to the fiscal agent. The attendance at selected review sessions and other on-site visits will be used to collect this data.

Objective 2 - Monitor the timeliness and accuracy of quarterly statistical reports.

Reports will be reviewed for accuracy and appropriateness of methodology. Internal reports resulting in the preparation of quarterly reports as well as a

sampling of documents will be used. NMPSRO may be required to furnish documentation regarding the content of any report or statistics produced. The timeliness will be considered using the date received by the Medical Assistance Bureau. The monitoring of this data shall be at the discretion of the Medical Assistance Bureau.

Objective 3 - Monitor the timeliness of the processing of prior approval requests.

The timeliness of processing prior approval requests will be monitored at the review sessions and other on-site visits. The date of receipt of the requests shall be considered with the date that the authorization is mailed to the provider. Attendance at selected review session and other on-site visits will be used to collect this data.

Objective 4 - Monitor the review process as described in the monitoring objectives.

Adherence to Medical Assistance Bureau Program policies, guidelines and criteria will be monitored by the attendance at selected review sessions, other on-site visits, and from a random selection of claims post payment supplied by the fiscal agent. The following shall be considered in monitoring the review process:

1. Claims and prior approval requests are given the level of review appropriate. Approvals, denials, and provider communications within the scope of responsibilities of the review assistants or review coordinator are to be handled at that level. Referrals to professional peer review, the Medical Assistance Bureau, and other review sources are to be appropriate.

2. Claims and prior approval requests are to be reviewed and processed according to the program benefits and limitations.

3. The consistancy of review is recognized as being a product of consistant interpretation of program policy, Ambulatory Review criteria, proper instruction to the professional reviewers by PSRO,

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and proper functioning of the review assistant and review coordinator. These elements shall all be considered in monitoring for consistancy of review.

4. The appropriateness of review determinations shall be monitored by considering the specific review decision in terms of common professional practice.

IV. On-site Reviews

The Medical Assistance Bureau will conduct on-site reviews, and attend review sessions and other necessary meetings with the recognition that the normal work flow of NMPSRO cannot be interrupted beyond what is necessary for the Medical Assistance Bureau to properly monitor performance. Recognizing also that the Medical Assistance Bureau is able to offer information regarding program policy and requirements, the following procedures will be followed at on-site visits:

1. Medical Assistance Bureau personnel may examine the material scheduled for review, attend the review session, or examine the material after the reviews are completed all at the discretion of the Medical Assistance Bureau.

2. Medical Assistance Bureau personnel in general will not discuss the review or program with the physician reviewers unless the reviewer specifically directs questions regarding program policy relevant to the review session to him or her. Medical Assistance Bureau personnel may clarify a service as not a program benefit if the review assistance fails to do so and the physician reviewer is approving a service which is not within the scope of the program.

3. Written notes will be taken at the review session regarding the review session regarding the appropriateness of the approvals, the level of review required, the adherence to Medical Assistance Bureau program policy and criteria, and the aged status of the material being reviewed.

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V. Reports to NMPSRO

The Medical Assistance Bureau will furnish to NMPSRO draft reports on their performance. NMPSRO will have 10 working days during which comments may be made to the Medical Assistance Bureau prior to finalizing the report. NMPSRO will receive a copy of the final report.

The State Agency will maintain regular periodic, informal contact with the PSRO and provide informal feed back on potential or existing problems. It is hopeful that many areas of concern or problems will be resolved at this level. However, at the discretion of the Medical Assistance Bureau NMPSRO may be required to produce a corrective action plan and/or document that specific problems are being resolved.

1. The Medical Assistance Bureau will inform the PSRO in writing of its concerns and will request a written explanation and/or the PSRO position on matters in question.

2. Upon receipt of the PSRO response, the Medical Assistance Bureau will review it and make a determination as to its satisfaction. If the State determines that the issues have been adequately explained and addressed by the PSRO, no further action will be necessary.

3. If the PSRO response is deemed not satisfactory, the Medical Assistance Bureau will request a meeting with the PSRO. If the issues can adequately be resolved at this meeting, the PSRO will confirm in writing any agreements and/or resolutions which result from the meeting and no further action will be required.

4. If the issues cannot be adequately resolved at this meeting the Medical Assistance Bureau will notify the PSRO in writing and request corrective action and response to the notification within 30 days.

5. If there has not been resolution of the problems within 30 days, the Medical Assistance Bureau will transmit all pertinent information to the Director of the Income Support Division for administrative action.

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Part IV - Special Provisions relating to IHS Hospitals

Indian Health Service Hospitals will be certified as Medicaid providers in the New Mexico Title XIX Program on the same basis as any other qualified provider. Medicare has implemented certain departures from reimbursement policies and procedures normally applied to Medicare hospitals in order to temporarily accomodate certain problems, primarily in the area of inadequate and untrained personnel in those institutions. Until these problems can be alleviated, Medicare and Medicaid will utilize per-diem rates established by the Office of Management and Budget for interim reimbursement and final settlement.

Directly related to the above procedure, the State of New Mexico has temporarily implemented the following procedures in order to allow IHS facilities to participate in the Title XIX Program.

A. IHS Facilities will use a newly developed procedural code for all outpatient visits and will not be required to enter all services provided on an outpatient basis.

   In order to accomplish utilization review on these claims it will be required that diagnosis be entered. This will enable the State to monitor overutilization by recipients and whether outpatient treatment is appropriate to the diagnosis. As staff can be augmented and trained normal claims submission will be required.